



Fox Valley
ANIMAL REFERRAL CENTER

FVARC USE

Date rcvd:	_____
# of films / size:	_____
# of films / size:	_____
# of films / size:	_____
Checked in by:	_____

Radiograph Referral Form / Report

USE THIS FORM WHEN REQUESTING A RADIOGRAPH REVIEW BY OUR RADIOLOGIST

REFERRING HOSPITAL

Referring veterinarian: _____ Date: _____ # of films: _____

Hospital name: _____ Phone: _____ Fax: _____

Patient name: _____ Client name: _____

Species: _____ Breed: _____ Sex: _____ Age: _____

Pertinent clinical history (use back if necessary):

FOX VALLEY ANIMAL REFERRAL CENTER (Please do not write below this point. For FVARC use only.)

Radiographic findings:

Thank you for this referral. If I can be of further assistance, please do not hesitate to call. Sincerely,

_____ Date _____

Faxed to RDVM

Date: _____

Time: _____

By: _____

billed

do not bill per _____

Films are being held at Fox Valley Animal Referral Center